BlueCross BlueShield Nebraska

IVIG (Intravenious Immunogobulin) Preauthorization Physician Fax Form

The following documentation is REQUIRED for preauthorization. Incomplete forms will be returned for additional information. For formulary information, please visit the Blue Cross and Blue Shield of Nebraska website at ***www.nebraskablue.com***

Patient Information

Today's Date: _____

Patient Name:

Insurance Information

BCBSNE ID Number:

Physician/Clinic Information

Prescriber Name:	Specialty:	
Clinic Name and Address:		
Clinic City, State, Zip Code:	Phone Number:	Secure Fax Number:

Preauthorization Information

Requested drug name (please specify brand): _____

Requested dose: _____ Length of treatment: _____

ICD-10 Diagnosis Code: _____

Place of Service:

- ☐ Physician's office
- ☐ Home self injection
- ☐ Home infusion
- ☐ Outpatient facility
- ☐ Infusion Center

Other: _____

Has this patient failed other treatments?..... ☐ Yes ☐ No

If yes, please provide past and present treatments for this indication including drug name, dates of therapy, and response to therapy: _____

_____

Please provide clinical information and documentation for the use of this medication. *If this is a renewal, please include updated labs, progress notes and other pertinent information*: _____

_____

Please fax or mail this form to:
Blue Cross and Blue Shield of Nebraska
Pharmacy Department - UM
1919 Aksarben Drive • PO Box 3248
Omaha, NE 68180-0001

Toll Free Fax: 877-232-6726
Phone: 877-999-2374